Example 2

Mr. S was admitted to the nursing home on 9/12/94 (Date of Entry) from an acute care hospital. The clinical staff established that 9/16/94 would be the MDS assessment reference date (last day of MDS observation period). By establishing 9/16/94 as the reference date, the observation period of 7 days extended back to 9/10/94 when Mr. S was still in the hospital. His hospital discharge summary mentioned that Mr. S was started on a daily dose of Prozac (an antidepressant) on 8/20. The hospital discharge summary was too sketchy to accurately determine if Mr. S received other medications during his hospital stay. Since admission to the nursing home Mr. S continues to receive the same dose of Prozac.

Coding

Medication	No. of days received
a. Antipsychotic:	"0" (days)
b. Antianxiety:	"0" (days)
c. Antidepressant:	"7" (days)
d. Hypnotic:	"0" (days)
e. Diuretic:	"0" (days)

SECTION P.
SPECIAL TREATMENTS AND PROCEDURES

1. Special Treatments, Procedures, and Programs

Intent: To identify any special treatments, therapies, or programs that the resident received in the specified time period.

a. SPECIAL CARE

TREATMENTS — The following treatments may be received by a nursing facility resident either at the facility, as a hospital out-patient, or in-patient basis, etc. Check the appropriate MDS item regardless of where the resident received the treatment.

Definition: Chemotherapy — Includes any type of chemotherapy (anticancer drug) given by any route.

Alzheimer's/dementia special care unit — Any identifiable part of the nursing facility, such as an entire or a contiguous unit, wing, or floor where staffing patterns and resident care interventions are designed specifically for cognitively impaired residents who may or may not have a specific diagnosis of Alzheimer's disease.

Hospice care — The resident is identified as being in a program for terminally ill persons where services are necessary for the palliation and management of terminal illness and related conditions.

Pediatric unit — Any identifiable part of the nursing facility, such as an entire or contiguous unit or wing where staffing patterns and resident care interventions are designed specifically for persons aged 22 or younger.

Respite care — Resident's care program involves a short-term stay in the facility for the purpose of providing relief to a nursing home-eligible resident's primary home based caregiver(s). Following this planned short stay, it is anticipated that the resident will return to his or her home in the community.

Training in skills required to return to the community — Resident is regularly involved in individual or group activities with a licensed skilled professional to attain goals necessary for community living (e.g., medication management, housework, shopping, using transportation, activities of daily living).

Process: Review the resident's clinical record.

Coding: Check all treatments and procedures that were received during the last 14 days. If no items apply in the last 14 days, check NONE OF ABOVE.

b. THERAPIES

Therapies that occurred after admission to the nursing home, were ordered by a physician, and were performed by a qualified therapist (i.e., one who meets state credentialing requirements or in some instances, under such a person's direct supervision).

The therapy treatment may occur either inside or outside the facility. Includes only therapies based on a therapist's assessment and treatment plan that is documented in the resident's clinical record.

Intent: To record the (A) number of days and (B) total number of minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 days.

Definition: **Speech-language pathology, audiology services** — Services that are provided by a qualified speech-language pathologist.

Occupational therapy — Therapy services that are provided or directly supervised by a qualified occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified occupational therapy assistant who is employed by (or under contract to) the nursing facility only if he or she is under the direction of a qualified occupational therapist.

Physical therapy — Therapy services that are provided or directly supervised by a qualified physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include service provided by a qualified physical therapy assistant who is employed by (or under contract to) the nursing facility only if he or she is under the direction of a qualified physical therapist.

Respiratory therapy — Included are coughing, deep breathing, heated nebulizers, aerosol treatments, and mechanical ventilation, etc., which must be provided by a qualified professional (i.e., trained nurse, respiratory therapist). Does not include hand held medication dispensers. Count only the time that the qualified professional spends with the resident.

Psychological therapy — Therapy given by any licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker.

Process: Review the resident's clinical record and consult with each of the qualified therapists.

Coding:

Box A: In the first column, enter the number (#) of days the therapy was administered for 15 minutes or more in the last seven calendar days. Enter "0" if none.

Box B: In the second column, enter the total number (#) of minutes the particular therapy was provided in the last seven days even if you entered "0" in Box A (e.g., less than 15 minutes of therapy provided). The time should include only the actual treatment time (not time waiting or writing reports). Enter"0" if none.

Example

Following a stroke Mrs. F was admitted to the nursing home in stable condition for rehabilitation therapies. Since admission she has been receiving speech therapy twice weekly for 30-minute sessions, occupational therapy twice weekly for 30-minute sessions, and physical therapy twice a day (30 minute sessions) for 5 days and respiratory therapy for 10 minutes per day on each of the last 7 days. During the last seven days Mrs. F has participated in all of her scheduled sessions.

Coding	A	B
a. Speech-language pathology, audiology services	2	60
b. Occupational therapy	2	60
c. Physical therapy	5	300
d. Respiratory therapy	0	70
e. Psychological therapy	0	0

2. Intervention Programs for Mood, Behavior, Cognitive Loss

Definition: **Special behavior symptom evaluation program** — A program of ongoing, comprehensive, interdisciplinary evaluation of behavioral symptoms (such as the symptoms described in item E4). The purpose of such a program is to attempt to understand the "meaning" behind the resident's behavioral symptoms in relation to the resident's health and functional status, and social and physical environment. The ultimate goal of the evaluation is to develop and implement a plan of care that serves to reduce distressing symptoms.

Evaluation by a licensed mental health specialist in the last 90 days — An assessment of a mood, behavior disorder, or other mental health problem by a qualified clinical professional such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker, depending on State practice acts. Do not check this item for routine visits by the facility social worker. Evaluation may take place at the nursing home, private office, clinic, community mental health center, etc.

Group therapy — Resident regularly attends sessions at least weekly. Therapy is aimed at helping to reduce loneliness, isolation, and the sense that one's problems are unique and difficult to solve. The session may take place either at the nursing home (e.g., support group run by the facility's social worker) or outside the facility (e.g., group program at community mental health center, Alcoholics Anonymous meeting at a local church, Parkinson's Disease support

group at local hospital). This item does not include group recreational or leisure activities.

Resident-specific deliberate changes in the environment to address mood/behavior/cognitive patterns — Adaptation of the milieu focused on the resident's individual mood/behavior/cognitive pattern. Examples include placing a banner labeled "wet paint" across a closet door to keep the resident from repetitively emptying all the clothes out of the closet, or placing a bureau of old clothes in an alcove along a corridor to provide diversionary "props" for a resident who frequently stops wandering to rummage. The latter diverts the resident from rummaging through belongings in other residents' rooms along the way.

Reorientation — Individual or group sessions that aim to reduce disorientation in confused residents. Includes environmental cueing in which all staff involved with the resident provide orienting information and reminders.

Process: Review the resident's clinical record for documentation of intervention programs. These interventions also should be documented in the care plan.

Coding: Check all that apply. If none apply, check *NONE OF ABOVE.*

3. Nursing Rehabilitation/Restorative Care

Intent: To determine the extent to which the resident receives nursing rehabilitation or restorative services from other than specialized therapy staff (e.g., occupational therapist, physical therapist, etc.). Rehabilitative or restorative care refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as is possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.

Skill practice in such activities as walking and mobility, dressing and grooming, eating and swallowing, transferring, amputation care, and communication can improve or maintain function in physical abilities and ADLs and prevent further impairment.

Definition: **Rehabilitation/restorative care** — Included are nursing interventions that assist or promote the resident's ability to attain his or her maximum functional potential. This item does not includle procedures or techniques carried out by or under the direction of qualified therapists, as identified in item P1b. In addition, **to be included in this section, a rehabilitation or restorative practice must meet all of the following additional criteria:**

- Measurable objectives and interventions must be documented in the care plan and in the clinical record.

- Evidence of periodic evaluation by licensed nurse must be present in the clinical record.

- Nurse assistants/aides must be trained in the techniques that promote resident involvement in the activity.

- These activities are carried out or supervised by members of the nursing staff. Sometimes under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents.

- This category does not include exercise groups with more than four residents per supervising helper or caregiver.

Range of motion — The extent to which, or the limits between which, a part of the body can be moved around a fixed point, or joint. Range of motion exercise is a program of passive or active movements to maintain flexibility and useful motion in the joints of the body.

Active range of motion — Exercises performed by a resident, with cueing or supervision by staff, that are planned, scheduled, and documented in the clinical record.

Splint or brace assistance — Assistance can be of 2 types: 1) where staff provide verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint, or 2) where staff have a scheduled program of applying and removing a splint or brace, assess the resident's skin and circulation under the device, and reposition the limb in correct alignment. These sessions are planned, scheduled, and documented in the clinical record.

Training and skill practice — Activities including repetition, physical or verbal cueing, and task segmentation provided by any staff member or volunteer under the supervision of a licensed nurse.

Bed mobility — Activities used to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side, and positioning him or herself in bed.

Transfer — Activities used to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.

Walking — Activities used to improve or maintain the resident's self-performance in walking, with or without assistive devices.

Dressing or grooming — Activities used to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.

Eating or swallowing — Activities used to improve or maintain the resident's self-performance in feeding one's self food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

Amputation/prosthesis care — Activities used to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket).

Communication — Activities used to improve or maintain the resident's self-performance in using newly acquired functional communication skills or assisting the resident in using residual communication skills and adaptive devices.

Other — Any other activities used to improve or maintain the resident's self-performance in functioning. This includes, but is not limited to, teaching self-care for diabetic management, self-administration of medications, ostomy care, and cardiac rehabilitation.

Process: Review the clinical record and the current care plan. Consult with facility staff. Look for rehabilitation, restorative care schedule, assignment, and implementation record sheet on the nursing unit.

Coding: For the last seven days, enter the number of days on which the technique, procedure, or activity was practiced for a total of at least 15 minutes during the 24-hour period. The 15 minutes does not have to occur all at once. Remember that persons with dementia learn skills best through repetition that occurs multiple times per day. Review for each activity throughout the 24-hour period. Enter zero "0" if none.

Examples of Nursing Rehabilitation/Restoration

Mr. V has lost range of motion (ROM) in his right arm, wrist and hand due to a CVA experienced several years ago. He has moderate to severe loss of cognitive decision-making skills and memory. To avoid further ROM loss and contractures to his right arm, the occupational therapist fabricated a right resting handsplint and instructions for its application and removal. The nursing coordinator developed instructions for providing passive range of motion exercises to his right arm, wrist and hand 3 times per day. The nursing assistants and Mr. V's wife have been instructed on how and when to apply and remove the handsplint and how to do the passive ROM exercises. These plans are documented on Mr. V's care plan. The total amount of time involved each day in removing and applying the handsplint and completing the ROM exercises is 30 minutes. The nursing assistants report that there is less resistance in Mr. V's affected extremity when bathing and dressing him. For both Splint or Brace assistance and Range of Motion (passive), **enter "7" as the number of days these nursing rehabilitative techniques were provided.**

Mrs. K was admitted to the nursing facility 7 days ago following repair to a fractured hip. Physical therapy was delayed due to complications and a weakened condition. Upon admission, she had difficulty moving herself in bed and required total assistance for transfers. To prevent further deterioration and increase her independence, the nursing staff implemented a plan on the second day following admission to teach her how to move herself in bed and transfer from bed to chair using a trapeze, the bedrails, and a transfer board. The plan was documented in Mrs. K's clinical record and communicated to all staff at the change of shift. The charge nurse documented in the nurses notes that in the five days Mrs. K has been receiving training and skill practice for bed mobility and transferring, her endurance and strength are improving, and she requires only extensive assistance for transferring. Each day the amount of time to provide this nursing rehabilitation intervention has been decreasing so that for the past five days, the average time is 45 minutes. **Enter "5" as the number of days training and skill practice for bed mobility and transfer was provided.**

Mrs. J had a CVA less than a year ago resulting in left-sided hemiplegia. Mrs. J has a strong desire to participate in her own care. Although she cannot dress herself independently, she is capable of participating in this activity of daily living. Mrs. J's overall care plan goal is to maximize her independence in ADL's. A plan, documented on the care plan, has been developed to teach Mrs. J how to put on and take off her blouse with no physical assistance from the staff. All of her blouses have been adapted for front closure with velcro. The nursing assistants have been instructed in how to verbally guide Mrs. J as she puts on and takes off her blouse. It takes approximately 20 minutes per day for Mrs. J to complete this task (dressing and undressing). **Enter "7" as the number of days training and skill practice for dressing and grooming was provided.**

(continued on next page)

Examples of Nursing Rehabilitation/Restoration (continued)

Using a quad cane and a short leg brace, Mrs. D is receiving training and skill practice in walking. Together, Mrs. D and the nursing staff have set progressive walking distance goals. The nursing staff have received instruction on how to provide Mrs. D with the instruction and guidance she needs to achieve the goals. She has three scheduled times each day where she learns how to apply her short leg brace followed by walking. Each teaching and practice episode for brace application and walking, supervised by a nursing assistant, takes approximately 15 minutes. **Enter "7" as the number of days for splint and brace assistance and training and skill practice in walking were provided.**

Experiencing a slow recovery from Guillain Barre syndrome, Mr. B is receiving daily training and skill practice in swallowing. Along with specially designed cups and appropriate food consistency, the documented plan of care to improve his ability to swallow involves proper body positioning, consistent verbal instructions, and jaw control techniques. Mr. B requires close monitoring when given food and fluids as he is at risk for choking and aspiration. Therefore, only licensed nurses provide this nursing rehabilitative intervention. It takes approximately 35 minutes each meal for Mr. B to finish his food and liquids. He receives supplements via a gastrostomy tube if her does not achieve the prescribed fluid and caloric intake by mouth. **Enter "7" as the number of days training and skill practice in swallowing was provided.**

Mr. W's cognitive status has been deteriorating progressively over the past several months. Despite deliberate nursing restoration, attempts to promote his independence in feeding himself, he will not eat unless he is fed. Because Mr. W did not receive nursing rehabilitation/restoration for eating in the last 7 days, **enter "0" as the number of days training and skill practice for eating was provided.**

Mrs. E has amyotrophic lateral sclerosis. She no longer has the ability to speak or even to nod her head "yes" and "no". Her cognitive skills remain intact, she can spell, and she can move her eyes in all directions. The speech language pathologist taught both Mrs. E and the nursing staff to use a communication board so that Mrs. E. could communicate with staff. The communication board has proven very successful and the nursing staff, volunteers and family members are reminded by a sign over Mrs. E's bed that they are to provide her with the board to enable her to communicate with them. This is also documented in Mrs. E's care plan. Because the teaching and practice in using the communication board had been completed two weeks ago and Mrs. E is able to use the board to communicate successfully, she no longer receives skill and practice training in communication. **Enter "0" as the number of days training and skill practice in communication was provided.**

4. Devices and Restraints

Intent: To record the frequency, over the last seven days, with which the resident was restrained by any of the devices listed below at any time during the day or night.

Definition: This category includes the use of any device (e.g., physical or mechanical device, material, or equipment attached or adjacent to the resident's body) that the resident cannot easily remove and that restricts freedom of movement or normal access to his or her body.

- **Full bed rails** — Full rails may be one or more rails along both sides of the resident's bed that block three-quarters to the whole length of the mattress from top to bottom. This definition also includes beds with one side placed against the wall (prohibiting the resident from entering and exiting on that side) and the other side blocked by a full rail (one or more rails). A veil screen (used in pediatric units) is included in this category.

- **Other types of bed rails used** (e.g., one-side half rail, one-side full rail, two-sided half rails).

- **Trunk restraint** — Includes any device or equipment or material that the resident cannot easily remove (e.g., vest or waist restraint).

- **Limb restraint** — Includes any device or equipment or material that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm) or lower extremity (i.e., foot, leg).

- **Chair prevents rising** — Any type of chair with locked lap board or chair that places resident in a recumbent position that restricts rising or a chair that is soft and low to the floor (e.g., bean bag chair). Includes "comfort cushions" (e.g., lap buddy), "merry walkers."

Process: Check the resident's clinical records and restraint flow sheets. Consult nursing staff. Observe the resident.

Coding: For each device type, enter:

0. Not used in last seven days

1. Used, but used less than daily in last seven days

2. Used on a daily basis in last seven days

5. Hospital Stay(s)

Intent: To record how many times the resident was admitted to the hospital with an overnight stay in the last 90 days or since the last assessment if less than 90 days [regardless of payment status for these days either by the hospital or by the nursing home]. If the resident is a new admission to the facility, this item includes admissions during the period prior to admission.

Definition: The resident was formally admitted by a physician as an in-patient with the expectation that he or she will stay overnight. It does not include day surgery, out-patient services, etc.

Process: Review the resident's record. If the resident is a new admission, ask the resident and resident's family. Sometimes transmittal records from recent hospital admissions are not readily available during a nursing home admission from the community.

Coding: Enter the number of hospital admissions in the box. Enter "0" if no hospital admissions.

Examples

Mrs. D, an insulin-dependent diabetic, was admitted to the nursing home yesterday from her own home. At home she had been having a lot of difficulty with insulin regulation since developing an ulcer on her left foot six weeks ago. During the last 90 days prior to admission, Mrs. D had two hospitalizations, for 3 and 5 days respectively. **Code "2" for two hospital admissions in the last 90 days.**

Mr. W has been a resident of the nursing facility for two years. He has a blood dyscrasia and receives transfusions at the local emergency room twice monthly. In the last month Mr. W was admitted to the hospital for 2 days after developing a fever during his blood transfusion. **Code "1" for one hospital admission in the last 90 days.**

6. Emergency Room (ER) Visit(s)

Intent: To record if during the last 90 days the resident visited a hospital emergency room (e.g., for treatment or evaluation) but was not admitted to the hospital for an overnight stay at that time. If the resident is a new admission to the facility, this item includes emergency room visits during the period prior to admission.

Definition: Emergency room visit — A visit to an emergency room not accompanied by an overnight hospital stay. Exclude prior scheduled visits for physician evaluation, transfusions, chemotherapy, etc.

Process: Review the resident's clinical record. For new admissions, ask the resident and the resident's family and review the transmittal record.

Coding: Enter the number of ER visits in the last 90 days (or since last assessment if less than 90 days). Enter "0" if no ER visits.

Examples

One evening, Mr. X complained of chest pain and shortness of breath. He was transferred to the local emergency room for evaluation. In the emergency room Mr. X was given IV Lasix, nitrates, and oxygen. By the time he stabilized, it was late in the evening and he was admitted to the hospital for observation. He was transferred back to the nursing home the next afternoon. **Code "0" for No ER visits.** The rationale for this coding is that although Mr. X was transferred to the emergency room, he was admitted to the hospital overnight. An overnight stay is not part of the definition of this item.

During the night shift, Mrs. F slipped and fell on her way to the bathroom. She complained of pain in her right hip and was transferred to the local emergency room for x-rays. The x-rays were negative for a fracture and Mrs. F was transferred back to the nursing home within several hours. **Code "1" for 1 ER visit.**

Once during the last 90 days, Mr. P's gastrostomy tube became dislodged and nursing home staff were unsuccessful in reinserting it after multiple attempts. Mr. P was then transferred to the local emergency room where the on-call physician reinserted the tube. **Code "1" for ER visit.**

7. Physician Visits

Intent: To record the number of days during the last 14-day period a physician has examined the resident (or since admission if less than 14 days ago). Examination can occur in the facility or in the physician's office. In some cases the frequency of physician's visits is indicative of clinical complexity.

Definition: Physician — Includes MD, osteopath, podiatrist, or dentist who is either the primary physician or consultant. Also include an authorized physician assistant, or nurse practitioner working in collaboration with the physician.

Physician exam — May be a partial or full exam at the facility or in the physician's office. This does not include exams conducted in an emergency

room. If the resident was examined by a physician during an unscheduled emergency room visit, record the number of times this happened in the last 90 days in Item P6, "Emergency Room (Visits)".

Coding: Enter the number of days the physician examined the resident. If none, enter "0".

8. Physician Orders

Intent: To record the **number of days** during the last 14-day period (or since admission, if less than 14 days ago) in which a physician has changed the resident's orders. In some cases the frequency of physician's order changes is indicative of clinical complexity.

Definition: **Physician** — Includes MD, DO (osteopath), podiatrist, or dentist who is either the primary physician or a consultant. Also includes authorized physician assistant or nurse practitioner working in collaboration with the physician.

Physician orders — Includes written, telephone, fax, or consultation orders for new or altered treatment. Does NOT include admission orders, return admission orders, or renewal orders without changes.

Coding: Enter the number of days on which physician orders were changed. Do not include order renewals without change. If no order changes, enter "0".

9. Abnormal Lab Values

Intent: To document whether the resident had any abnormal laboratory values during the last 90 days. This item refers only to laboratory tests performed after admission to the nursing home. "Abnormal" refers to laboratory values that are abnormal when compared to standard values, not abnormal for the particular resident.

Example

An elevated prothrombin time in a resident receiving coumadin therapy is coded "1" for Yes (Abnormal) even though this may be the desired effect.

Process: Check medical records, especially laboratory reports.

Coding: Enter "0" if no abnormal value was noted in the record, and "1" if the resident has had at least one abnormal laboratory value.

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1. Discharge Potential

Intent: To identify residents who are potential candidates for discharge within the next three months. Some residents will meet the "potential discharge" profile at admission; others will move into this status as they continue to improve during the first few months of residency.

Definition: Discharge — Can be to home, another community setting, another care facility, or a residential setting. A prognosis of death should not be considered as an expected discharge.

Support person — Can be a spouse, family member, or significant other.

Process: For new and recent admissions, ask the resident directly. The longer the resident lives at the facility, the tougher it is to ask about preferences to return to the community. After one year of residency, many persons feel settled into the new lifestyle at the facility. Creating unrealistic expectations for a resident can be cruel. Use careful judgement. Listen to what the resident brings up (e.g., Calls out, "I want to go home"). Ask indirect questions that will give you a better feel for the resident's preferences. For example, say, "It's been about 1 year that we've known each other. How are things going for you here at (facility)".

Consult with primary care and social service staff, the resident's family, and significant others. Review clinical records. Discharge plans are often recorded in social service notes, nursing notes, or medical progress notes.

Coding:

a. **Resident expresses/indicates preference to return to the community.** Enter "0" for No or "1" for Yes.

b. **Resident has a support person who is positive towards discharge.** Enter "0" for No or "1" for Yes.

c. **Stay projected to be of a short duration** — Discharge projected within 90 days (do not include expected discharge due to death). Enter "0" for No, "1" for within 30 days, "2" for within 31-90 days, or "3" for discharge status uncertain.

Examples

Mrs. F is a 65 year old married woman who sustained a CVA 2 months ago. She was admitted to the nursing facility one week ago from a rehabilitation facility for further rehab, particularly for transfer, gait training, and wheelchair mobility. Mrs. F is extremely motivated to return home. Her husband is supportive and has been busy making their home "user friendly" to promote her independence. Their goal is to be ready for discharge within 2 months.

Discharge Potential	**Coding**
a. Resident expresses/indicates preference to return to the community.	1 (Yes)
b. Resident has a support person who is positive towards discharge.	1 (Yes)
c. Stay projected to be of a short duration — discharge projected within 90 days (do not include expected discharge due to death).	2 (Within 31-90 days)

Mrs. D is a 67 year old widow with end-stage metastatic cancer to bone with pathological fractures. Currently her major problems are pain control and confusion secondary to narcotics. Mrs. D periodically calls out for someone to take her home to her own bed. Her daughter is unwilling and unable to manage her hospice care at home. Because of the fractures, Mrs. D is totally dependent in all ADLs except eating (she can hold a straw).

Discharge Potential	**Coding**
a. Resident expresses/indicates preference to return to the community	1 (Yes)
b. Resident has a support person who is positive towards discharge	0 (No)
c. Stay projected to be of short duration — discharge projected within 90 days (do not include expected discharge due to death).	0 (No)

Rationale for coding:
Although Mrs. D is near death, you should apply a code of "0" (No). This MDS item instructs you "do not include expected discharge due to death."

Examples (continued)

Mr. S is a 70 year old married gentleman who was admitted to the facility 2 weeks ago from the hospital following surgical repair of a left hip fracture. Mr. S has a long history of alcoholism and cirrhosis of the liver. His daughter reports that when he is drinking he is abusive towards his wife of 40 years. Though he has a strong wish to return home, his wife states she can't take it anymore and doesn't want him to return home. He has basically worn out all his family options. Other social support options are being explored. At this time plans for discharge remain uncertain.

Discharge Potential	Coding
a. Resident expresses/indicates preference to return to the community.	1 (Yes)
b. Resident has a support person who is positive towards discharge.	0 (No)
c. Stay projected to be of a short duration — discharge projected within 90 days (do not include expected discharge due to death).	3 (Uncertain)

2. Overall Change in Care Needs

Intent: To monitor the resident's overall progress at the facility over time. Document changes as compared to his or her status of 90 days ago (or since last assessment if less than 90 days ago). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Definition: **Overall self-sufficiency** — Includes self-care performance and support, continence patterns, involvement patterns, use of treatments, etc.

Process: Review clinical record, transmittal records (if new admission or readmission), previous MDS assessments (including quarterly reviews), and care plan. Discuss with direct caregivers.

Coding: Record the number corresponding to the most correct response. Enter "0" for No change, "1" for Improved (receives fewer supports, needs less restrictive level of care), or "2" for Deteriorated (receives more support).

Examples

Mr. R is a 90 year old comatose gentleman admitted to the facility from a 6 months stay at another nursing facility to be closer to his wife's residence. His condition has remained unchanged for approximately 6 months. **Code "0" for No change.**

Mrs. T has a several year history of Alzheimer's disease. In the past four months her overall condition has generally improved. Although her cognitive function has remained unchanged, her mood is improved. She seems happier, less agitated, sleeps more soundly at night, and is more socially involved in daily activity programming. **Code "1" for Improved.**

Mr. D also has a several year history of Alzheimer's disease. Although for the past year he was quite dependent on others in most areas, he was able to eat and walk with supervision until recently. In the past 90 days he has become more dependent. He no longer feeds himself. Additionally, he fell 2 weeks ago and has been unable to learn how to use a walker. He requires a 2 person assist for walking even short distances. **Code "2" for Deteriorated.**

SECTION R.
ASSESSMENT INFORMATION

1. Participation in Assessment

Intent: To record the participation of the resident, family and/or significant others in the assessment, and to indicate reason if the resident's assessment is incomplete.

Definition: **Family** — A spousal, kin (e.g., sibling, child, parent, nephew), or in-law relationship.

Significant other — May include close friend, lover, house mate, legal guardian, trust officer, or attorney. Significant other does not, however, include staff at the nursing facility.

Process: Preparing residents and family members to participate in the care-planning process begins with assessment. When staff members explain the assessment process to a resident, they should also explain that the outcome of assessment is care delivery guided by a care plan. Every assessment team member can establish an expectation of resident participation by asking for and respecting the resident's perspective during assessment.

Asking family members about their expectations of the nursing facility and their concerns during the assessment process can prove beneficial. Relatives may need to talk to a staff member or they may need information. Some family concerns and expectations can be appropriately addressed in the care-planning conference. Discussing these matters with the family during the assessment process can assist in maintaining a focus on the resident during the care-planning meeting.

Staff should consider some important aspects of resident and/or family participation in assessment and care planning. Attention to seating arrangements that will facilitate communication is necessary for several reasons:

- To keep the resident from feeling intimidated and/or powerless in front of professionals.
- To accommodate any communication impairments.
- To minimize any tendencies for family members to dominate the resident in the conference yet encourage them to support the resident if that is needed.
- To facilitate nonverbal support of the resident by staff with whom the resident is close.

Verbal communication should be directed to the resident, even when the resident is cognitively impaired. The terms used should be tailored to facilitate understanding by the resident. The resident's opinions, questions, and responses to the developing care plan should be solicited if they are not forthcoming.

Coding:

a) **Resident** — Enter zero "0" for No or "1" for Yes to indicate whether the resident participated in the assessment. This item should be completed last.

b) **Family** — Enter zero "0" for No or "1" for Yes to indicate whether the family participated; enter "2" for No family.

c) **Significant other** — Enter "0" for No or "1" for Yes to indicate whether a significant other participated; enter "2" for None if there is no significant other.

2. Signatures of Persons Completing the Assessment

Intent: Federal regulations at 42 CFR 483.20 (c) (1) and (2) require each individual who completes a portion of the assessment to sign and certify its accuracy. These regulations also require the RN Assessment Coordinator to sign and certify that the assessment is complete.

Process: Each staff member who completes any portion of the MDS must sign and date the MDS and indicate beside their signature which portions they completed. Two or more staff members can complete items within the same section of the MDS. The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS. The RN Assessment Coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.

Coding: All persons completing part of this assessment, including the RN Assessment Coordinator, must sign their names in the appropriate locations. To the right of the name, enter title and the letters that correspond to sections of the MDS for which the assessor was responsible, and also enter the date on which the form is signed. Federal regulation requires the RN Assessment Coordinator to sign and thereby certify that the assessment is complete.

SECTION S.
STATE DEFINED SECTION

SECTION S IS RESERVED FOR ADDITIONAL STATE-DEFINED ITEMS. THERE IS NO SECTION S IN THE FEDERAL VERSION 2.0 MDS FORM. YOUR STATE MAY CHOOSE TO DESIGNATE A SECTION S.

SECTIONS T AND U ARE SUPPLEMENTAL SECTIONS FOR USE IN THE CASE-MIX AND QUALITY DEMONSTRATION STATES. COPIES OF THE SECTION T AND U FORMS ARE AT THE END OF THIS CHAPTER AND IN APPENDIX B.

SECTION T.
SUPPLEMENT ITEMS FOR MDS 2.0 IN CASE-MIX AND QUALITY DEMONSTRATION STATES

1. Special Treatments and Procedures

a. RECREATION THERAPY

Intent: To record the (A) number of days and (B) total number of minutes recreation therapy was administered (for at least 15 minutes a day) in the last 7 days.

Definition: Recreation Therapy -- Therapy ordered by a physician that provides therapeutic stimulation beyond the general activity program in a facility. The physician's order must include a statement of frequency, duration and scope of the treatment. Such therapy must be provided by a State licensed or nationally certified Therapeutic Recreation Specialist or Therapeutic Recreation Assistant. The therapeutic recreation assistant must work under the direction of a therapeutic recreation specialist.

Process: Review the resident's clinical record and consult with the qualified recreation therapists.

Coding: Box A: In the first column, enter the number (#) of days the therapy was administered for 15 minutes or more in the last seven days. Enter "0" if none.

Box B: In the second column, enter the total number (#) of minutes recreational therapy was provided in the last seven days. The time should include only the actual treatment time (not resident time waiting for treatment or therapist time documenting a treatment). Enter "0" if none.

b. ORDERED THERAPIES (item b, c, and d)

Skip this item unless this is a Medicare 5 day assessment, or initial admission assessment.

Intent: To recognize ordered and scheduled therapy services [physical therapy (PT), occupational therapy (OT) and speech pathology services (SP)] during the early days of the resident's stay. Often therapies are not initiated until after the end of the observation assessment period. This section provides an overall picture of the amount of therapy that a resident will likely receive through the fifteenth day from admission.

Process: For Item 1B: Review the resident's clinical record to determine if the physician has ordered one or more of the therapies to begin in first 14 days of stay. Therapies include physical therapy (PT), occupational therapy (OT), speech pathology services. If not, skip to item 2. If orders exist, consult with the therapists involved to determine if the initial evaluation is completed and therapy treatment(s) has been scheduled. If therapy treatment(s) will **not** be scheduled, skip to item 2.

If the resident is scheduled to receive at least one of the therapies, have the therapist(s) calculate the total number of days through the resident's fifteenth day since admission when at least one therapy service will be delivered. Then have the therapist(s) estimate the total PT, OT, and SP treatment minutes that will be delivered through the fifteenth day of admission.

Coding: Item c. Enter the number (#) of days at least one therapy service can be expected to have been delivered through the resident's fifteenth day of admission.

Item d. Enter the estimated **total** number of therapy minutes (across all therapies) it is expected the resident will receive through the resident's fifteenth day of admission.

Example of Ordered Therapies

Medicare 5 day assessment:
Mr. Z was admitted to the nursing home late Thursday afternoon. The physician's orders for both physical therapy and speech language pathology evaluation were obtained on Friday. Both therapy evaluations were completed on Monday and physical and speech therapy were scheduled to begin on Tuesday. Physical therapy was scheduled 5 days a week for 60 minutes each day. Speech therapy was scheduled for 3 days a week for 60 minutes each day. The RN Assessment Coordinator identified Monday as the end of the observation assessment period for this Medicare 5 day assessment. Within the 15 days from the resident's admission date (Thursday), the resident will receive 8 days of physical therapy (480 minutes) and 4 days of speech therapy (240 minutes) for a total of 720 minutes in the fifteen days.

Enter "8" in 1.c for the number of days that at least one therapy service is expected to be delivered.

Because physical therapy was scheduled more frequently than speech therapy, the total number of days of physical therapy would be used.

Enter "720" in 1.d for the estimated total number of minutes that both physical therapy and speech therapy are expected to be delivered.

(continued on next page)

information will provide a picture of the resident's problems and level of functioning for comparison to the most self-sufficient walking episode. This information will assist all members of the interdisciplinary care team to differentiate the resident's "best walking effort" and the resident's usual walking performance. Discussions between the physical therapist working with the resident on walking and the RN Assessment Coordinator regarding these differences should lead to better coordination of care and foster continuity of physical therapy treatment for the resident on the nursing unit.

Assessment of the resident's most self-sufficient walking episode can be used to evaluate 1) the effectiveness of physical therapy and nursing rehabilitation, 2) the continued need for therapy and nursing rehabilitation, and 3) maintenance of walking ability after therapy or nursing rehabilitation was discontinued.

Complete item 2 when the following conditions are present. Otherwise, skip to item 3.

- **ADL self-performance score for TRANSFER (G.1.bA) is 0, 1, 2, or 3**

AND

- **Resident receives physical therapy (P.1.b.c) involving gait training;**

OR

- **Physical therapy is ORDERED for gait training (T.1.b)**

OR

- **Resident is receiving nursing rehabilitation for walking (P.3.f)**

OR

- **Physical therapy involving gait training has been discontinued within the past six months.**

Definition: **Most self-sufficient episode--In the last seven days, the episode in which the resident used the LEAST amount of assistance and support while walking the longest and farthest without sitting down.** The most self-sufficient episode can include physical help from others or assistive devices. Only episodes using a safe, functional gait should be used in determining the walking episode that was the most self-sufficient.

Assistive devices: Prostheses, different types of canes and walkers, crutches, splints, parallel bars, and pushing a wheel chair for support.

Coding:

a. Furthest distance walked--For the most self-sufficient episode using a safe and functional gait pattern, record the distance that the resident walked. Use the following codes:

0. 150 or more feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b.Time walked--For the same episode (T.3.a), record the time it took the resident to walk the distance. Use the following codes:

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31 or more minutes

c. Self-performance in walking--For the same episode (T.3.a), record the amount of assistance the resident received during the walking episode. Use the following codes:

0. INDEPENDENT--No help or oversite provided while walking.
1. SUPERVISION--Oversight, encouragement, or cuing provided while walking.
2. LIMITED ASSISTANCE--Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance.
3. EXTENSIVE ASSISTANCE--Resident received weight bearing assistance while walking.

d. Walking support provided--For the same episode (T.3.a), record the amount of support the resident received during the walking episode. Use the following codes:

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two or more persons physical assist

e. Parallel bars used during walking--For the same episode(T.3.a), record if parallel bars were used. Code "0" if parallel bars were NOT used and "1" if parallel bars were used.

CODING EXAMPLES FOR WALKING WHEN MOST SELF SUFFICIENT

Mrs. D was admitted to the nursing facility 1 month ago for rehabilitation following a CVA. She has left sided hemiplegia and receives physical therapy 5 days a week for a 45 minute session twice daily. Mrs. D enjoys her PT sessions and puts forth her best efforts in walking when her therapist is present. During the last 7 days, Mrs. D's most self-sufficient episode was during a physical therapy session when she walked the length of the hallway outside the physical therapy room (approximately 50 feet) in 15 minutes without sitting down. Mrs. D used a short leg brace to prevent foot drop and a quad cane for support. The physical therapist walked beside Mrs. D, encouraging her and cueing her to pick up her left foot, but not providing physical support.

Code a (furthest distance walked) as "2"

Code b (longest time) as "3"

Code c (self-performance) as "1"

Code d (walking support provided) as "0"

****

Mr. G was admitted to the nursing facility following a lengthy hospitalization related to injuries sustained in a motor vehicle accident. Mr. G received physical therapy for 8 weeks to strengthen his lower extremities. Physical therapy was discontinued last week. Mr. G tires during the day, requiring more assistance with ambulation as the day progresses. During the morning, Mr. G walks from his bed to the toilet room (8 feet) with oversight from a staff person. It takes about 6 minutes for Mr. G to reach the toilet room. He uses a brace on his right leg and a walker which the staff put on for Mr. G.

During the night shift, Mr. G has much difficulty in bearing weight and manipulating his lower extremities. To walk to the toilet room, two nursing assistants are needed to provide weight-bearing support and to help Mr. G position his legs in taking steps. It takes approximately 6 minutes to reach the toilet room.

Code a (furthest distance) as "4"

Code b (longest time) as "2"

Code c (self-performance) as "1"

Code d (walking support provided) as "1"

SECTION U. MEDICATIONS

Nursing home residents are highly susceptible to adverse drug reactions and drug interactions. It is estimated that approximately 30% of all geriatric hospital admissions are due to drug-related problems. Polypharmacy is the use of two or more medications for no apparent reasons or for the same purpose. Polypharmacy also occurs when a medication is used to treat an adverse reaction from another medication. Polypharmacy can occur in nursing homes when there is no regular and careful monitoring of residents' prescribed medications.

Intent: This section will assist staff in identifying potential problems related to polypharmacy, drug reactions and interactions. Further, this section can also help staff to identify potential physical and emotional problems a resident may be experiencing. For example, reviewing and documenting the frequency a resident uses a PRN pain medication, sleeping medication, or laxative may lead the interdisciplinary team to do further assessment related to underlying causes associated with the use of PRN medications. Many of the RAPs and Triggers refer to assessment of medications in which this section would be very helpful.

In addition to using the medication information collected in Section U for resident care planning purposes, this section can be integrated into a facility's quality assurance program to monitor for quality care issues such as polypharmacy, overuse of different medications, and medication administration errors and omissions.

Finally, facilities in Case-mix Demonstration States are required to collect medication information. The drug-use data are linked to the assessment data for monitoring the quality and cost-efficiency of care in a Medicare/Medicaid payment system.

Definitions: Amount Administered--the number of tablets, capsules, suppositories, or amount of liquid (cc's, mls, units) per dose that is administered to a resident.

NDC--the National Drug Code (NDC) is a standardized system for coding medications. An individual NDC provides coded information on the drug name, dose, and form of the drug.

Medication Administration Record (MAR)--the part of the resident's clinical record that is used by the nurse administering medications to record the medication administered. The MAR typically is the form or document used specifying the medication, dose, frequency, and route for each medication that a resident is to receive on a scheduled or PRN basis.

Process: Recording all of the information required in this section can be done efficiently by having the following information: 1) current physician order sheets; 2) current Medication Administration Record (MAR), 3) NDC codes. Use the Medication Administration Record (MAR) as your primary document for identifying all medications administered in the last seven days. Check the physician's order sheet to determine if any medications had recently been ordered.

In some facilities, the pharmacist may complete some portions of Section U, particularly the NDC codes and the amount administered. The pharmacy may also be able to supply you with the NDC codes for the medications ordered for each resident. Talk to the pharmacist for your facility and engage their participation in assisting with the completion of this section. If the pharmacist does not complete any portions of the medication section of the MDS, you will need to consult the list of NDC codes. The manual provides the NDC codes for medications frequently used in nursing facilities. In addition, NDC codes can be found in the *Physicians Drug Reference (PDR)* or you may be able to obtain a list of NDC codes from your pharmacy.

Take special care to ensure that you have identified and recorded all medications that were administered in the last 7 days. Often residents can have several MAR pages, especially if medications have been discontinued and new ones ordered or if there are a lot of PRN medications ordered. Recheck the MAR at least twice to avoid missing any medications administered in the last seven days. Make sure you count medications that may have been discontinued, but were administered in the last seven days.

To accurately complete the NDC codes and amount administered, it will be necessary to look at the actual medications that are given to the resident. For example, some injectable medications can be provided in vials, ampules, or premeasured syringes.

If Section U is completed by the pharmacist or other nursing home personnel, these persons must certify its accuracy with their signature in section R.2. The RN Assessment Coordinator must review Section U to ensure that it is complete.

Coding: The coding instructions are extensive. Review them carefully. Study the examples. Complete the coding exercises at the end of this section.

1. **Medication Name and Dose Ordered.** Identify and record all medications that the resident <u>received</u> in the last seven days. Also identify and record any medications that may not have been given in the last seven days, but are part of the residents regular medication regimen (e.g. monthly B-12 injections). Do not record PRN medications that were not administered in the last seven days.

Record the name of the medication and dose that was ordered by the physician in column 1. Write the name of the medication and dose ordered *EXACTLY* as it appears on the MAR. For example, if the MAR indicates Acetaminophen 650 mg, do not write Acetaminophen 325 mg. 2 tabs--even if two 325 mg. tablets are administered to the resident.

Occasionally, dosages of medications may be changed during the seven day assessment period. The medication with dosage changes should be recorded separately.

EXAMPLE FOR MEDICATION NAME AND DOSE ORDERED

Medications as listed on MAR for assessment period of 8/11/94-8/17/94

A. Lasix 40 mg. daily p.o.
B. Acetaminophen 325 mg. 2 tabs q3-4 hrs PRN p.o. (given 3 times in last seven days)
C. B-12 1cc q month IM (given 8/8/94)
D. Isopto Carbachol 1.5% 2 drops OD TID
E. Robitussin-DM 5cc HS PRN p.o. (not given in last 7 days)
F. Motrin 300 mg. QID p.o. (discontinued 8/15/94)
G. Dilantin 300 mg. HS p.o. (ordered 8/15/94)
H. Theo-Dur 200 mg. BID p.o. (given 8/11-8/13/94 and then order discontinued)
I. Theo-Dur 200 mg TID p.o. (given 8/14-8/16/94 and then order discontinued)
J. Theo-Dur 400 mg BID p.o. (given 8/17)

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN-n	6. NDC Codes
Lasix 40 mg.					
Acetaminophen 325 mg. 2 tabs					
B-12 1cc					
Isopto Carbachol 1.5% 2 drops					
Motrin 300 mg.					
Dilantin 300 mg.					
Theo-Dur 200 mg.					
Theo-Dur 200 mg.					
Theo-Dur 400 mg.					

*Note that Robitussin-DM was not recorded because it was not given in the last 7 days.

2. Route of Administration. Determine the Route of Administration (RA) used to administer each medication. The MAR and the physician's orders should identify the RA for each medication. Record the RA in column 2 using the following codes:

1=by mouth (PO)	5=subcutaneous (SQ)	8=inhalation
2=sub lingual (SL)	6=rectal (R)	9=enteral tube
3=intramuscular (IM)	7=topical	10=other
4=intravenous (IV)		

EXAMPLE FOR ROUTE OF ADMINISTRATION

Medications as listed on MAR for assessment period of 8/11/94-8/17/94

A. Mylanta 15 cc after meals p.o.
B. Zantac 150 mg. q 12 hrs. Per tube
C. Transderm nitro patch 2.5 1 patch daily
D. Humulin N 15 U before breakfast daily SQ
E. Lasix 80 mg. IV STAT
G. Acetaminophen suppository 650 mg. q 4 hrs. PRN (given on 2 occasions in last 7 days)

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5.PRN-n	6. NDC Codes
Mylanta 15cc	1				
Zantac 150 mg.	9				
Transderm nitro patch 2.5 1 patch	7				
Humulin N 15 U	5				
Lasix 80 mg.	4				
Acetaminophen suppository 650 mg.	6				

3. Frequency. Determine the number of times per day, week, or month that each medication is given. Record the frequency in column 3 using the following codes:

PR=(PRN) as necessary	2D=(BID) two times daily	QO=every other day
1H=(QH) every hour	(includes every 12 hrs)	4W=4 times each week
2H=(Q2H) every two hours	3D=(TID) three times daily	5W=five times each week
3H=(Q3H) every three hours	4D=(QID) four times daily	6W=six times each week
4H=(Q4H) every four hours	5D=five times daily	1M=(Q mo) once every month
6H=(Q6H) every six hours	1W=(Q week) once each wk	2M=twice every month
8H=(Q8H) every eight hours	2W=two times every week	C=continuous
1D=(QD or HS) once daily	3W=three times every week	O=other

Be careful to differentiate between similar frequencies. For example, some nursing facilities have a policy that antibiotics are to be administered around the clock. Therefore, if an antibiotic is ordered as T.I.D., the medication may actually be given q 8 hours. There is a different frequency code for T.I.D. (3D) and q 8 hrs (8H). In this case, the frequency code would be 8H (q 8 hrs.).

If insulin is given on a sliding scale, each different dose of insulin given is entered as a PRN medication.

EXAMPLE FOR FREQUENCY

Medications as listed on MAR for assessment period of 8/11/94-8/17/94

A. Ampicillin 250 mg. q 6 hrs x 10 days p.o. (8/10-8/20)
B. Beconase nasal inhaler 1 puff BID
C. Compazine suppository 5 mg. STAT
D. Lanoxin 0.25 mg. p.o. every other day. On alternate days, give Lanoxin 0.125 mg. p.o.
E. Peri-colace 2 capsules HS p.o.
F. Humulin N 15 U before breakfast daily SQ
G. Check blood sugar daily at 4 p.m. Sliding scale insulin: Humulin R 5 units if blood sugar 200-300; 10 units if over 300. (5 units given on 8/11/94 for BS of 255; 5 units given on 8/13/94 for BS of 233; 10 units given on 8/17/94 for BS of 305)

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5.PRN-n	6. NDC Codes
Ampicillin 250 mg.	1	6H			
Beconase nasal inhaler 1 puff	8	2D			
Compazine suppository 5 mg.	6	PR			
Lanoxin 0.25 mg.	1	QO			
Lanoxin 0.125 mg.	1	QO			
Peri-colase 2 capsules	1	1D			
Humulin N 15 U	5	1D			
Humulin R 5U	5	PR			
Humulin R 10 U	5	PR			

4. Amount Administered (AA). Determine the amount of medication administered each time the medication was given. Amount administered **is not always** the dose. Rather, it is the number of tablets, capsules, suppositories, or amount of liquid (cc's, mls, units) **per dose** that is administered to a resident. For **tablets, capsules or suppositories,** enter the ***number*** of tablets or capsules that were given for each *administration* in column 4 (e.g. 1, 2, 1.5) For **liquids,** enter the ***number*** of cc's, mls, or units that were given for each *administration* in column 4 (e.g. 0. 5 ml, 2.5 cc, 10 units). For **topical medications** (e.g. creams, ointments, eye drops), **inhalation medications,** and **oral medications that are dissolved in water,** enter the numeric code **999** in column 4. If a half of tablet or half of cc is administered, enter it as a decimal (0.5) rather than a fraction.